ISSUE BRIEF
AN UPDATE ON WOMEN'S HEALTH POLICY

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Medicaid: A Critical Source of Support for Family Planning in the United States

Medicaid is the joint federal-state program that finances health services for over 52 million low-income individuals. Over the years, the program has become increasingly important as a source of public funding for family planning. Since the mid-1980s, it has been the single largest source of public dollars supporting family planning services and supplies nationwide. As such, the policies set by Medicaid are critical to the delivery of publicly supported family planning in the United States.

Medicaid is now the nation's largest health care program and the largest source of federal support to states. Medicaid expenditures comprise approximately 17% of all state spending. With so many dollars at stake, Medicaid's future has been the subject of widespread debate. Over the last few years, many states confronting serious budget shortfalls have cut back on Medicaid eligibility and services in a variety of ways; a recent study found that all 50 states implemented Medicaid cost-control strategies in 2004 and planned additional action in 2005.[1] Similarly, at the federal level, cuts in Medicaid spending and major program restructuring have been proposed and are under consideration.

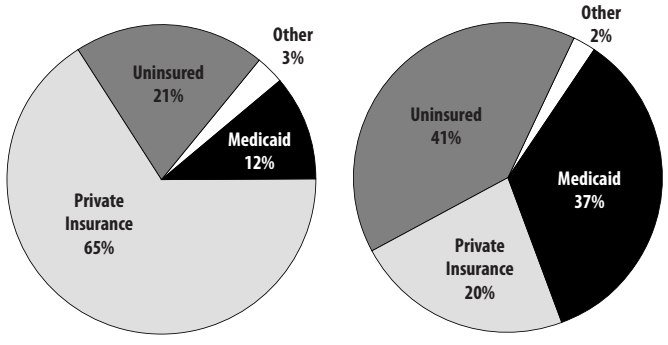
Together, these developments underscore the importance of understanding the role of Medicaid to the provision of publicly funded family planning services and especially for the individuals who need this preventive health care. This *Issue Brief* reviews: the extent to which women of reproductive age rely on Medicaid for their care; the special status that family planning has long had under Medicaid; the range of services covered under the rubric of family planning; the 21 state-initiated Medicaid family planning expansions that have extended eligibility for Medicaid-funded family planning to millions of men and women who otherwise would not be covered; and, the effectiveness and cost-effectiveness of subsidized family planning in reducing unintended pregnancies and births, as well as abortions, especially among teenagers and unmarried women.

Women's Reliance on Medicaid

When enacted in 1965, Medicaid focused on families on welfare, primarily single women and their children. Over time, the program has expanded to cover many elderly, blind and disabled individuals. Although these groups now comprise 25% of beneficiaries, they account for 69% of the program's cost. Children and their parents, who make up 75% of beneficiaries, account for only 31% of total expenditures.[2]

Medicaid plays a critical role for women in general, and for reproductive-age women in particular. In 2003, 7.1 million women of reproductive age (15 to 44), 11.5% of that group, looked to Medicaid for their care, including family planning. For poor women, the proportion is even higher: 36.6% of women of reproductive age in families with incomes below the federal poverty line ($15,260 for a family of three) were enrolled in Medicaid in 2003 (see Figure 1).[3] Women are more likely to qualify for Medicaid than men because women tend to be poorer and tend to meet the program's strict eligibility criteria; seven in 10 Medicaid beneficiaries older than age 14 are women.[4]

Figure 1
Health Insurance Coverage of Women of Reproductive Age (15 to 44), 2003



All Women of Reproductive Age (N = 61.7 million)

Women of Reproductive Age Below Poverty (N= 9.1 million)

Note: The federal poverty level was $15,260 for a family of three in 2003.
Source: The Alan Guttmacher Institute, special tabulations of data from Current Population Survey, 2004.

The proportion of reproductive-age women enrolled in Medicaid varies by state, reflecting differences both in income and in state-defined eligibility criteria (see Figure 2). The proportion of all women of reproductive age enrolled in Medicaid in 2002–2003 ranged from 5% in New Hampshire to a high of 20% in Maine and the District of Columbia. In eight states and the District of Columbia, at least 15% of all women of reproductive age looked to Medicaid for their care; in 18 states, fewer than one in 10 women were covered under the program. At the same time, one in five (20.5%) women of reproductive age remain uninsured, ranging from 10% in Minnesota to 33% in Texas.

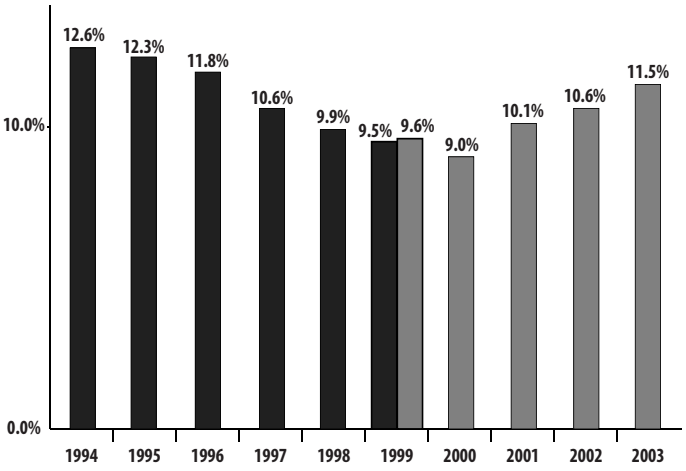
Figure 2
Percent of Women of Reproductive Age (15 to 44) Enrolled in Medicaid and Uninsured, by State, 2002–2003

State	Medicaid	Uninsured	State	Medicaid	Uninsured
Alabama	10.5	18.3	Montana	10.9	23.1
Alaska	12.3	21.1	Nebraska	9.1	13.5
Arizona	12.6	22.7	Nevada	5.8	25.0
Arkansas	11.7	24.9	New Hampshire	5.3	14.7
California	12.4	23.1	New Jersey	8.1	16.7
Colorado	6.3	19.9	New Mexico	14.2	31.7
Connecticut	10.2	13.6	New York	15.4	19.2
Delaware	12.5	12.6	North Carolina	10.4	22.5
District of Columbia	20.1	15.1	North Dakota	11.6	11.3
Florida	8.6	24.7	Ohio	11.2	15.1
Georgia	6.9	22.1	Oklahoma	8.8	25.9
Hawaii	9.8	13.4	Oregon	11.7	21.7
Idaho	10.6	23.2	Pennsylvania	10.5	15.4
Illinois	9.5	17.8	Rhode Island	17.6	13.6
Indiana	7.4	16.8	South Carolina	15.7	19.1
Iowa	8.7	14.0	South Dakota	10.5	15.1
Kansas	7.4	15.0	Tennessee	18.0	14.2
Kentucky	12.7	17.9	Texas	8.6	33.4
Louisiana	13.2	28.7	Utah	8.8	15.1
Maine	20.3	13.0	Vermont	19.8	12.8
Maryland	6.0	15.8	Virginia	5.5	17.2
Massachusetts	13.5	11.5	Washington	13.8	18.8
Michigan	12.5	15.6	West Virginia	15.1	23.0
Minnesota	11.3	10.4	Wisconsin	13.5	10.8
Mississippi	17.1	21.3	Wyoming	8.1	23.4
Missouri	11.2	14.5			
U.S. Total (2003)				**11.5***	**20.5***

Source: The Alan Guttmacher Institute, special tabulations from the 2003 and 2004 Current Population Surveys. *U.S. total is for 2003.

In the mid-1990s, the proportion of women ages 15 to 44 enrolled in Medicaid declined, a trend that most observers attribute both to the passage in 1996 of legislation overhauling the nation's welfare system and to the economic boom the country was experiencing during that period.[5] Although the welfare legislation included provisions aimed at preserving Medicaid coverage for families no longer eligible for welfare, these provisions proved confusing for beneficiaries and states alike, and were extremely difficult to implement. Since 2000, however, Medicaid enrollment—in general and among reproductive-age women—has increased, in part in response to the deteriorating economic climate, and as the welfare reform transitions have smoothed out (see Figure 3).

Figure 3
Women of Reproductive Age (15 to 44) Covered Under Medicaid, 1994–2003



*In March 2000, the Census Bureau made significant changes to questions in the CPS, resulting in more accurate estimates. Because of these changes, insurance enrollment figures from 1999 and beyond are not directly comparable with previous years.
Source: The Alan Guttmacher Institute, special tabulations of data from the Current Population Survey, 1995–2004.

In 1998, more than two million Medicaid beneficiaries—one third of all women ages 15 to 44 covered under the program that year—obtained a Medicaid-covered family planning service, which include both reversible contraception and sterilization.[6] One in four clients receiving services through publicly funded family planning clinics had their care paid for by Medicaid in 1999. In the same year, eight in 10 agencies providing publicly subsidized family planning services reported serving Medicaid beneficiaries.[7]

Special Status for Family Planning

Even though family planning has long enjoyed a special status in the Medicaid program, that was not the case when the program was enacted nearly 40 years ago. At that point, each state had the authority to decide even whether to cover the service or not.

While the majority of states voluntarily included family planning services in their early Medicaid efforts, important gaps remained.[8] Nine of the 48 states participating in Medicaid in 1970—Alabama, Arkansas, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Texas and Wyoming—did not cover family planning at all. Other states provided only limited access. Colorado and Montana, for example, did not pay for services provided by clinics. Florida and Oregon required beneficiaries seeking family planning services to first obtain authorization from the local welfare agency. North Dakota required such authorization for beneficiaries seeking prescription drugs, including oral contraceptives. Kentucky and Missouri covered contraceptive drugs, but not "birth control devices," such as IUDs.

Over the course of the 1960s, evidence began to emerge that unintended childbearing—especially among teenagers—could have serious social and economic consequences, including increased poverty and reliance on public assistance.[9] Similarly, researchers began to appreciate that repeated, closely spaced births or childbearing very early or late in the reproductive years could lead to adverse health outcomes for both mothers and their children.

Congress acknowledged the importance of family planning as well as the uneven coverage of the service across state Medicaid programs when it adopted omnibus amendments to the program in 1972. These amendments established a legal entitlement to family planning for Medicaid beneficiaries nationwide by expanding the benefit package required of all state Medicaid programs to include "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies."[10] Notably, although prescription drugs in general are covered at the states' option, contraceptives are included under the family planning mandate as family planning supplies and, therefore, are required for all state programs.

Enhanced Matching Rate

As an incentive to further encourage states to make family planning services widely available to Medicaid beneficiaries, the 1972 amendments also established a special matching rate of 90% for family planning services and supplies.[11] In general, the cost of providing care to Medicaid beneficiaries is shared by the federal and state governments. States are assigned a "federal financial participation" rate, the proportion of the cost of providing services for which they will be reimbursed by the federal government. These "matching rates," which range from 50% to 77% of the cost of services, are inversely related to per capita income in the state, so that less-affluent states are reimbursed by the federal government at a higher rate. For family planning, however, the federal government matches the cost of all services and supplies at 90% for all states. Given that not even the poorest states could claim federal matching at that level for the costs of providing other medical services, and that some states could claim only 50%, this rate offered all states a clear incentive.

Exempt from Cost-Sharing

The Medicaid statute includes two other key provisions aimed at improving access to family planning for beneficiaries. The first concerns the cost-sharing that may be required of Medicaid beneficiaries. For most services covered under Medicaid, states may require beneficiaries to incur "nominal" out-of-pocket costs. The federal statute, however, exempts family planning (and a small number of other services) from this requirement, regardless of the requirements placed on other services, drugs or supplies under the state program.[12] As a result, Medicaid beneficiaries are entitled to obtain family planning services and supplies without incurring any out-of-pocket costs.

There are some indications, however, that the prohibition on cost-sharing may not be adhered to universally. In a 1996 study of 27 Medicaid managed care plans in five states, two plans reported requiring a copayment for family planning. Nine percent of Medicaid managed care enrollees surveyed in those states reported having been charged fees for contraceptive services, and 3% indicated that they had discontinued use of a contraceptive method because of the cost.[13]

"Freedom of choice" for managed care beneficiaries

The second key provision relates to Medicaid managed care enrollees seeking family planning services. This is a critical issue since 82% of women on Medicaid are enrolled in managed care plans[14] and the clinics from which many Medicaid beneficiaries traditionally have obtained their family planning have faced an array of challenges in pursuing arrangements with managed care plans.[15] Although states may require Medicaid beneficiaries to enroll in managed care plans and obtain care from providers affiliated with those plans, the federal statute makes an exception for family planning services and supplies in most cases.[16] Accordingly, most Medicaid managed care enrollees may obtain family planning services from any provider within their plan or, if they prefer, go outside of their plan to obtain services from the Medicaid-participating provider of their choice.

While retaining freedom of choice for enrollees is critical, it has proven to be difficult to achieve, for a variety of reasons.[17] First, freedom of choice is often allowed for only a limited

package of services; this can cause difficulties both for the individuals seeking treatment and the providers seeking to meet their patients' needs. For example, providers may be reimbursed for diagnosing a sexually transmitted disease, but not for providing treatment following diagnosis. Second, systems in which providers attempt to obtain reimbursement from a managed care plan, rather than directly from the state, have often resulted in a lack of timely and adequate payment. Third, enrollees are often not adequately informed or aware of their ability to go out of plan to obtain care.

Managed care poses other challenges as well in relation to the provision of family planning services.[18] Legislation enacted by Congress in 1997 allows a Medicaid managed care plan (whether or not religiously controlled, or even affiliated) to opt out of providing services under certain circumstances. Specifically, this provision gives plans the right to refuse "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds."[19] In addition, expenditures for family planning services are often included in aggregate payments, known as capitation payments, to health plans, rather than as discrete payments for family planning. This makes it difficult to ascertain accurate expenditures for family planning services and supplies under the program, and for states to claim the enhanced 90% match from the federal government.

Range of Services Covered as Family Planning

Guidelines developed by the Health Care Financing Administration, the federal agency that administers the Medicaid program and now known as the Centers for Medicare and Medicaid Services (CMS), describe the package of services considered family planning under Medicaid only in broad terms.[A] According to CMS, states may claim the federal match for 90% of the costs of covering services that meet these broad guidelines (see Figure 4) and states "are free to determine the specific services and supplies which will be covered as Medicaid family planning services" within these broad guidelines.[20]

Under the CMS guidelines, services must be "expected to achieve a family planning purpose" in order to be reimbursed at the 90% rate. Tests to screen for sexually transmitted diseases (STDs), for example, are covered at 90% "when performed routinely as part of an initial or regular or follow-up visit/examination for family planning." However, "if a routinely performed screening test indicates that the patient has a medical condition/problem which requires treatment," this treatment is not considered a family planning service and would not be eligible for the 90% federal matching rate. Rather, it would be covered under the state's regular matching rate.[21]

Figure 4
Federal Guidelines for Medicaid Family Planning Benefit

Under the broad federal guideline that family planning services should "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size, states may cover:

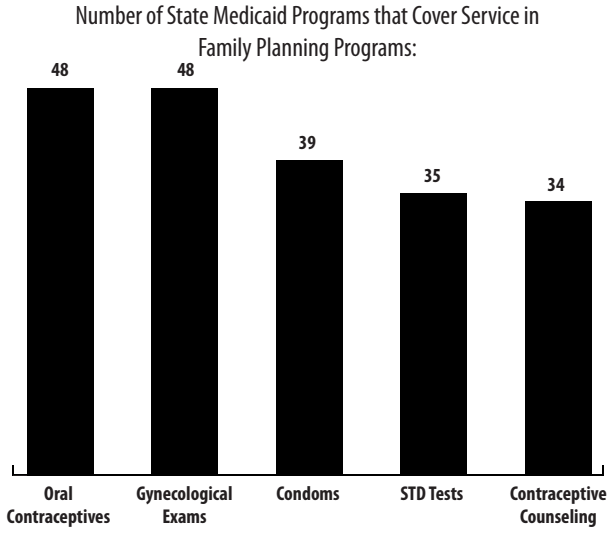
- Counseling services and patient education
- Examination and treatment by medical professionals in accordance with applicable state requirements
- Laboratory examinations and tests
- Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception
- Infertility services, including sterilization reversals

Source: State Medicaid Manual, Part 4: Services, www.cms.hhs.gov.

Within these general guidelines, state Medicaid programs cover an array of critical services under the rubric of family planning. All state programs cover a range of Food and Drug Administration–approved contraceptive methods, often including over-the-counter methods. All 47 states and the District of Columbia responding to a survey as of January 2000 indicated that they covered the IUD, injectable contraceptives and oral contraceptives, and a slightly lower number reported covering the diaphragm.[22] Forty-two states and the District of Columbia indicated that they covered at least one over-the-counter method, such as condoms, spermicides and the contraceptive sponge. Thirty-four states covered contraceptive counseling as a separate family planning service (see Figure 5).

[A] Under CMS policy, abortion "may not be claimed as a family planning service" under any circumstances. However, federal law allows abortion to be covered under Medicaid when the woman's life would be endangered if the pregnancy were carried to term and in cases of rape or incest; states may obtain reimbursement for these procedures under their regular federal reimbursement rates, rather than the special 90% family planning rate. Furthermore, individual states remain free to use their own funds to pay for other "medically necessary" abortions for Medicaid beneficiaries, and 17 do so as of January 2005.

Figure 5
Selected Family Planning Services Offered by State Medicaid Programs, 2000



Note: 47 states and the District of Columbia responded to this survey.
Source: Schwalberg, R., et al., *Medicaid Coverage of Family Planning Services*, Kaiser Family Foundation, 2001.

The survey also found that 27 states and the District of Columbia covered emergency contraception, although the method was relatively new to the market at that point. A subsequent study found that 10 states that had not reported covering emergency contraception in 2000 were providing coverage in 2001.[23] In addition, nearly all states responding to the survey had begun covering two newer methods, the contraceptive patch and the contraceptive ring.

All 47 states and the District of Columbia responding to the 2000 survey reported covering gynecological exams as of January 2000. Similarly, nearly all programs indicated that they covered testing for cervical cancer and STDs, as well as STD treatment.

Nonetheless, whether these related services are considered family planning or must be provided at the state's regular Medicaid matching rate depends on the specific service and the circumstances in which it is delivered. This distinction is significant for states, because of the preferential federal matching rate. But it is important to beneficiaries as well, because the ban against cost-sharing and the freedom to choose providers applies only to those services considered family planning.

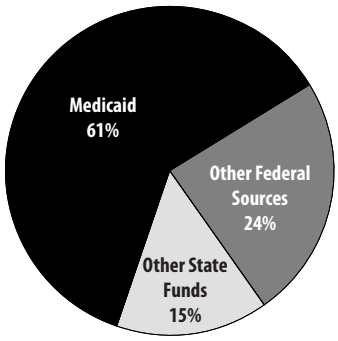
Nearly all Medicaid programs cover tubal ligation for women and vasectomy for men. (Regulations promulgated in 1978 govern the provision of federally funded sterilizations; they specify a procedure for obtaining informed consent, require a 30-day waiting period and prohibit sterilization of anyone younger than 21 or mentally incompetent.[24])

A sterilization performed primarily for contraceptive purposes is within the definition of family planning, although a sterilization performed for the treatment of a medical condition is not.[25]

A Major Source of Public Funding

Although expenditures for family planning services and supplies comprise only one-third of one percent of overall Medicaid program expenditures,[26] it is a critical source of financing for family planning services for low-income women. Over the course of the last quarter-century, Medicaid's importance in financing family planning has been increasing. In 1980, Medicaid contributed approximately 20% of all public funds spent to provide contraceptive services and supplies. By the mid-1980s, Medicaid had become the single largest source of public funding. In 2001, the program provided six in 10 of all public dollars spent, far surpassing the Title X national family planning program (15%), and other programs (see Figure 6).[27]

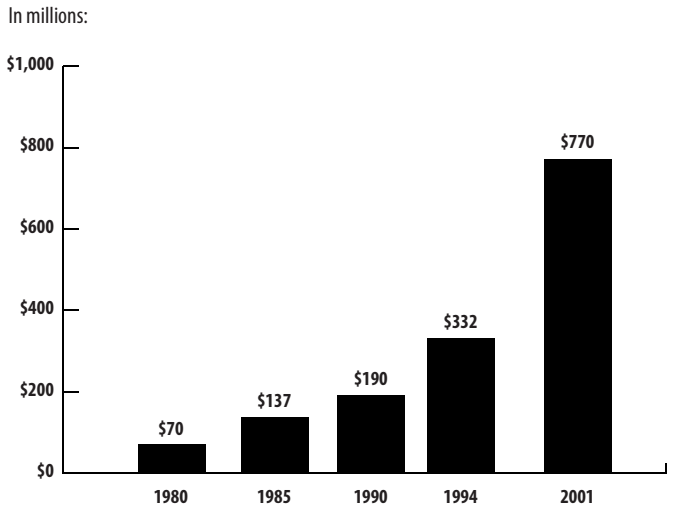
Figure 6
Sources of Public Funding for Family Planning Services, 2001



Note: Other Federal Sources includes Title X (15%), MCH Block Grant (4%), TANF (4%), and Social Service Block Grant (1%).
Source: Sonfield, A. and Gold, R.B., *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001*, New York: The Alan Guttmacher Institute, 2005.

Medicaid spending on family planning services and supplies has grown dramatically in recent years, from about $100 million in the early 1980s, to nearly $350 million in 1994 to $770 million in 2001 (see Figure 7). This increase parallels growth in overall Medicaid spending. Total Medicaid expenditures for medical services grew by 75% from 1995 to 2002.[28] However, the rate of increase for family planning has been considerably slower than the rate of growth for prescription drug expenditures overall, which rose by 150% between 1994 and 2000.[29]

Figure 7
Medicaid Expenditures for Family Planning Services and Supplies, Selected Fiscal Years 1980–2001



Sources: Sollom, T., Gold, R.B., and Saul, R., "Public Funding for Contraceptive, Sterilization and Abortion Services, 1994," *Family Planning Perspectives*, July/August 1996, pp. 166–173; and Sonfield, A. and Gold, R.B., *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001*, New York: The Alan Guttmacher Institute, 2005, www.guttmacher.org/pubs/fpfunding/index.html.

The growth in Medicaid spending for contraceptive services is due to a combination of factors, including sharply increasing costs of providing care across the health care system. Furthermore, as discussed below, state Medicaid family planning eligibility expansions have extended Medicaid eligibility for family planning services to new individuals who otherwise would not have been able to enroll, or remain enrolled, in the program; the seven states with these programs accounted for two-thirds of the increase in Medicaid family planning expenditures between 1994 and 2001.[30] While there has been much discussion about recent increases in Medicaid spending, Medicaid cost inflation seems to parallel increases evident throughout the health sector.

In addition, rapid growth in family planning spending is not only limited to Medicaid. A recent survey of a small number of agencies receiving grants under the Title X program found that the average per-client cost to purchase contraceptive supplies and tests for STDs and cervical cancer rose 19% just between 1998 and 2001.[31]

In 2001, all but seven states and the District of Columbia spent more than $1 million for family planning services and supplies through their Medicaid programs (see Figure 8). Eight states spent at least $20 million in that year, with California alone reporting more than $260 million dollars in Medicaid expenditures for family planning services and supplies.[‡32]

Figure 8
Medicaid Expenditures on Family Planning Services, by State, FY 2001 (in thousands of dollars)

State	Expenditures ($)	State	Expenditures ($)
Alabama	15,258	Montana	1,513
Alaska	153	Nebraska	1,809
Arizona	12,717	Nevada	2,541
Arkansas	12,769	New Hampshire	722†
California	260,636	New Jersey	14,200
Colorado	4,606	New Mexico	3,861†
Connecticut	13,777	New York	57,925*
Delaware	2,532	North Carolina	11,909
District of Columbia	113*	North Dakota	733*
Florida	18,865	Ohio	12,973
Georgia	11,584	Oklahoma	12,162
Hawaii	178†	Oregon	19,211
Idaho	972	Pennsylvania	30,183
Illinois	14,948*	Rhode Island	2,034
Indiana	17,169	South Carolina	26,607
Iowa	2,409	South Dakota	417
Kansas	1,047*	Tennessee	23,622
Kentucky	4,389*	Texas	31,144
Louisiana	8,836	Utah	1,484
Maine	4,079	Vermont	3,384
Maryland	11,920	Virginia	13,671*
Massachusetts	21,430	Washington	8,986*
Michigan	11,936	West Virginia	1,089*
Minnesota	2,919*	Wisconsin	5,193†
Mississippi	4,492	Wyoming	712
Missouri	21,811		
U.S. Total			**769,627**

Notes: All figures are estimates based on unpublished data from the Centers for Medicare and Medicaid Services (CMS) and include all federal Medicaid expenditures at the family planning matching rate of 90% (excluding sterilization services and administrative services), plus a 10% state matching contribution.

* Adjusted to include expenditures for women in capitated managed care plans. Adjustment factor inflated CMS-reported expenditures by 50% of the percentage of women 15–44 on Medicaid who were in capitated managed care, as reported to AGI. For Washington State, this adjustment was applied to all CMS-reported expenditures except those through the state's Medicaid family planning waiver.

† Adjusted to include expenditures for women in managed care plans. Adjustment factor inflated CMS-reported expenditures by 50% of the percentage of Medicaid enrollees who were in managed care, as reported by CMS.

Sources: CMS, unpublished data, July 2003; CMS, 2001 Medicaid Managed Care Enrollment Report, 2002, accessed on http://www.cms.gov/medicaid/managedcare/mcsten01.pdf on October 23, 2003; and The Alan Guttmacher Institute, unpublished data from FY 2001 Survey of State Medicaid Agency Expenditures on Reproductive Health, 2003.

[‡]California has implemented a Medicaid family planning expansion program. Despite serving over 1.5 million women, California's expenditure for family planning services and supplies was only about 1% of total Medicaid spending in the state in 2001.

Notably, other sources of funding for family planning services have not matched the trajectory of family planning expenditures under Medicaid. Appropriations for Title X, the only federal program focused solely on family planning services, have declined by nearly 60% since 1980, when inflation is taken into account.[33] State revenues, historically another significant contributor to the public funding landscape, have suffered in all areas, including family planning, as a result of the recent economic downturn, with several states reporting significant cuts to the family planning line-item in their budgets in recent years.[34]

Medicaid Family Planning Expansions

Over the past decade, several states have sought and received permission from CMS to extend Medicaid eligibility for family planning services to large numbers of individuals whose incomes are above the very low state-set levels for regular Medicaid enrollment or who do not meet the other requirements for Medicaid enrollment. These programs have extended coverage to many who otherwise would be ineligible for Medicaid-subsidized services (see Figure 9).

When Medicaid was first established, the low-income families covered generally were single mothers and their children receiving welfare cash assistance. In the 1980s, Congress broke the welfare-Medicaid link for low-income pregnant women by first allowing—and later requiring—states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care (specifically including postpartum family planning services) to all women with incomes up to 133% of the federal poverty level for up to 60 days postpartum—far above most states' regular Medicaid eligibility ceilings. At their option, states could expand eligibility for pregnancy related services to women with incomes up to 185% of poverty or beyond.[35]

Building on the expansions for pregnancy-related care, several states in recent years have moved to expand eligibility for Medicaid family planning services as well. Because these expansions limit the scope of coverage of Medicaid benefits to family planning supplies, services and some related care, states seeking to adopt these programs must obtain approval—generally through a research and demonstration "waiver"—from CMS. Waivers are one avenue for states to make program alterations that go beyond federal Medicaid guidelines. These waivers are limited both in scope—in this case to family planning—and in time—to an initial five-year period, although states may apply for an extension. Once approval of a family planning waiver is secured, the state may claim federal reimbursement for 90% of the costs of providing family planning services and supplies under the effort.

States can design waivers in a number of manners, but the proposal must be "budget neutral" to the federal government over the five-year span of the effort; that is, they cannot cost the federal government more than it would have spent in the absence of the waiver. States that have obtained these waivers have argued that the cost of providing family planning services and supplies to individuals under the program pales in comparison to the cost of providing pregnancy-related services to beneficiaries who would otherwise become pregnant and eligible for Medicaid-funded prenatal, delivery and postpartum care.

A newer requirement, instituted in 2001 by the Bush administration, is that family planning waiver programs must facilitate access to primary care. To meet this requirement, states must generally have arrangements with primary care providers to whom clients may be referred when needed. States must develop written materials for clients explaining how they can access primary care services and the impact of providing these referrals must be included in the state's evaluation of its family planning waiver.[36]

Figure 9
State Medicaid Family Planning Eligibility Expansions as of April 2005

State	Basis for Eligibility			Eligible Population Includes Men	Limited to Individuals ≥19	Expiration Date
Approved	Losing Coverage Postpartum	Losing Coverage for Any Reason	Based Solely on Income (% of Poverty)			
Alabama			133%		X	9/30/2005
Arizona	2 Years					9/30/2006
Arkansas			200%			1/31/2006
California			200%	X		6/30/2005
Delaware		2 Years				12/31/2006
Florida	2 Years					11/30/2006
Illinois		5 Years			X	3/31/2009
Maryland	5 Years					5/31/2005
Minnesota			200%	X		*
Mississippi			185%			9/30/2008
Missouri	1 Year					3/1/2007
New Mexico			185%		X	9/30/2006
New York			200%	X		3/31/2006
North Carolina			185%	X	X	†
Oklahoma			185%	X	X	†
Oregon			185%	X		10/31/2006
Rhode Island	2 Years					7/31/2005
South Carolina			185%			6/30/2005
Virginia	2 Years					9/30/2007
Washington			200%	X		6/30/2006
Wisconsin			185%			12/31/2007
Total in Effect	**6**	**2**	**13**	**7**	**5**	

* Expansion was approved on 7/20/2004 and will expire five years after the implementation date.
† Expansion was approved on 11/5/2004 and will expire five years after the implementation date.

Source: The Alan Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief*, April 1, 2005.

Varied Approaches to Coverage

In general, the states' Medicaid family planning eligibility expansions have taken one of three routes.[37] The first built directly on the expansions for pregnancy-related care, which allow states to provide Medicaid-funded family planning services and supplies, as part of postpartum care, for 60 days after a woman gives birth. Under this provision, unless a woman qualifies for Medicaid under a different eligibility pathway, she would lose her Medicaid coverage after the 60 days postpartum period. Led by Rhode Island and South Carolina in 1993, six states currently have federal approval to continue coverage for family planning services, generally for two years postpartum, although Maryland provides coverage for five years after delivery.

Delaware and Illinois have varied this approach somewhat and continue Medicaid coverage for family planning for individuals leaving the Medicaid program for any reason, not just following childbirth.

The third approach has been to extend Medicaid coverage for family planning services to residents who had not been previously covered under the program at all. Beginning with Arkansas and South Carolina, 13 states currently have federal permission to expand their income-eligibility levels for Medicaid-covered family planning services at least up to the eligibility level in place for Medicaid-covered maternity care.[B]

These programs provide a broad package of services to enrolled individuals. For example, Alabama's program, known as Plan First, covers initial and periodic visits, counseling and education, testing for cervical cancer and STDs, pregnancy testing, STD/HIV counseling, contraceptive services and supplies, and sterilization services. The direct services are augmented with bio-psychosocial assessment and care coordination for women at high risk for an unintended pregnancy.[38]

While most of the expansions cover beneficiaries for the full span of their reproductive lives, five of the programs—in Alabama, Illinois, New Mexico, North Carolina and Oklahoma—only cover women who are 19 or older.

Significantly, seven programs—in California, Minnesota, New York, North Carolina, Oklahoma, Oregon and Washington—provide coverage to men as well as women. For calendar year 2002, California reported that 11% of the program's clients were men.[39]

The California effort is unique in its attempt to address a long-standing and widely acknowledged problem in Medicaid—its cumbersome and time-consuming enrollment process. Historically, enrolling in Medicaid often entailed applying in person at the local welfare agency, something that has long been considered a significant deterrent. Under the California program, enrollment occurs at the point of service, obviating the need for a client to make multiple visits and avoiding the stigma of an association with welfare. Instead, family planning providers use information from the client to determine eligibility; eligible clients are then issued a card that enables them to access services.[40]

A Significant Impact

Together, the state Medicaid family planning eligibility expansions have assisted large numbers of low-income people who otherwise might have had no source of coverage for family planning (see Figure 10).[41] Of the 13 states that had waiver programs operating in 2001, 12 were able to provide data on the number of beneficiaries served through these programs. Together, these 12 states reported 1.7 million clients, 1.3 million of whom were served through the massive California program. The seven states that could provide expenditure data on a recent survey spent $71 million under their waivers, two-thirds of which was spent in California.

Figure 10
Clients Served in State Medicaid Family Planning Eligibility Expansion Programs, 2001

State and Expansion Type	Number Served
Postpartum	
Arizona	15,131
Florida	18,854
Maryland	23,301
Missouri	u
Rhode Island	935*
Leaving Medicaid for any Reason	
Delaware	879
Income Based	
Alabama	68,767
Arkansas	44,773
California	1,270,000
New Mexico	21,951*
Oregon	81,610
South Carolina	62,238
Washington	73,108
Total	**1,676,547**

Source: Gold, RB, "Medicaid Family Planning Extensions Hit Stride," The Guttmacher Report on Public Policy, October 2003, pp. 11-14.
* Data are number of clients enrolled in program, not actually served.

[B] California began its effort in 1997 by creating an entitlement to family planning for residents with incomes up to 200% of poverty. Initially, the effort was funded entirely with state dollars. In 1999, California submitted and received approval for a Medicaid waiver, making the program eligible for federal reimbursement.

Clients served through the California program, known as Family PACT, receive a range of services.[42] More than seven in 10 clients served through the program in FY 2000–2001 received a contraceptive method, six in 10 received one or more STD tests and more than half were tested for cervical cancer.

A national evaluation of Medicaid family planning waivers conducted by the CNA Corporation along with the schools of public health at Emory University and the University of Alabama at Birmingham, under a contract with CMS, has provided important evidence of the impact of the waivers.[43] According to the study, all six of the programs studied resulted in significant savings to both the federal and state governments. Moreover, the researchers found evidence that some of the programs expanded access to care, improved the geographic availability of services, expanded the diversity of family planning providers and resulted in a measurable reduction in unintended pregnancy (see Figure 11).

A recent study of publicly funded family planning services nationwide found that publicly funded clinics in the seven states with income-based expansions in 2001 were able to meet more of the need for subsidized contraceptive services than clinics in other states. Clinics in the expansion states served half of the women in need, while clinics in other states served 40%. Between 1994 and 2001—years during which the seven expansions began—clinics in expansion states increased both the proportion of the need being met and the number of clients served by about one-quarter; clinics in states without expansion programs did not gain any ground.[44]

Evidence from the California Experience

Publicly subsidized family planning service providers have a long and well-established track record of providing effective—and cost-effective—care. Nationwide, including services provided through Medicaid as well as other public programs, the investment made in family planning each year helps 1.3 million women avoid an unintended pregnancy.[45] Nationally, each dollar spent to provide publicly funded family planning services saves $3 in expenditures for pregnancy-related and newborn care just to the Medicaid program alone.

Absent that investment in publicly funded family planning services, it is estimated that the number of abortions performed in the United States each year would be 40% higher than it currently is.[46] The number of teenage births would increase by one-quarter and the number of teenage abortions would increase by nearly 60%. Total out-of-wedlock births would be one-quarter higher than is currently the case.

Figure 11
Impact of State Medicaid Family Planning Eligibility Expansions

			Net Savings from Expansion Program		
State	**Year**	**Births Averted**	**Total**	**State Share***	**Federal Share**
Alabama	2000-2001	3,612	$19,028,783	$6,981,721	$12,047,062
Arkansas	1997-1998	2,748	$15,524,056	$5,199,426	$10,324,630
	1998-1999	4,486	$29,748,208	$9,411,954	$20,336,254
California	1999-2000	21,335	$76,182,694	$64,314,302	$11,868,392
New Mexico	1998-1999	507	$1,334,435	$652,918	$681,517
	1999-2000	1,358	$5,009,165	$2,037,590	$2,971,575
	2000-2001	1,528	$6,510,909	$2,650,439	$3,860,470
Oregon	2000	5,414	$19,756,294	$11,077,646	$8,678,648
South Carolina	1994-1995	2,228	$13,634,174	$4,135,453	$9,498,721
	1995-1996	3,151	$19,615,968	$6,201,946	$13,414,022
	1996-1997	3,769	$23,066,926	$7,403,462	$15,663,464

Source: Edwards, J., Bronstein, J., and Adams, K., "Evaluation of Medicaid Family Planning Demonstrations," The CNA Corporation, CMS Contract No. 752-2-415921, November 2003.
* State share of savings calculated by The Alan Guttmacher Institute, based on the total savings and the federal share of savings in the final report by the CNA Corporation.

Data on the impact of family planning services funded just through Medicaid, rather than through a variety of federal and state sources, comes from California. A review of medical records shows that while nearly one-third of new clients were not using any contraception or were using a low-efficacy method prior to their first Family PACT visit, 95% left with a highly effective method.[47]

By comparing the contraceptive methods used prior to Family PACT with the methods obtained through the program, researchers estimate that in calendar year 2002, Family PACT prevented 213,000 unintended pregnancies, 45,000 of which would have been to teenagers. By preventing these pregnancies, the program helped women in California avoid a total of 82,000 abortions, 16,000 of which would have been to teenagers.[48]

Conclusion

Given the overall economic and budgetary climate nationally and in state capitals across the country, debates over the future of Medicaid are likely to be a part of the political landscape for some time to come. Concerns over continued increases in the cost of providing health care and the mounting number of individuals who lack any health insurance whatsoever are likely to fuel these debates. These debates raise several key issues of importance to the provision of family planning services that stand to be affected by any fundamental changes to the Medicaid program:

Status of family planning as a mandatory benefit

Family planning is an important component of preventive care for women. Because these services are defined as "mandatory" benefits under the program, women on Medicaid are assured coverage for family planning services and supplies. As a mandatory benefit, women should continue to have access to family planning even at times when states may be facing budget shortfalls and scaling back on benefits.

Exemption from cost-sharing

Family planning's exemption from cost-sharing under Medicaid has helped facilitate access to care and ensure that these services are affordable for low-income women. Research has demonstrated that cost-sharing requirements, such as deductibles and co-payments for office visits or prescription drugs can act as barriers to care and result in reduced use of health care services, particularly for low-income women .[49] Medicaid's ban on cost-sharing for family planning services has helped to assure that cost will not be a barrier to this preventive service for low-income women.

Freedom to choose family planning providers

Given the highly sensitive, confidential, and specialized nature of reproductive health care and the proliferation of managed care and faith-based plans in Medicaid, it is important for women to be able to see the family planning provider of their choice. By allowing women to maintain their relationships with their family planning providers, even when they are enrolled in managed care networks, continuity of care and confidentiality is protected.

Enhanced federal matching rate

The 90% federal match has given states an important incentive to facilitate and broaden access to family planning services. The enhanced match has enabled several states to expand the range of family planning services to include many screening as well as preventive services and to take additional steps to promote greater beneficiary education about family planning. Furthermore, the enhanced 90% match has been a strong incentive for states to extend coverage through state expansion programs to women who may not otherwise qualify for Medicaid. These programs have been very popular at the state level and some policymakers have proposed that states be given broader authority to expand family planning coverage by eliminating the need to apply for family planning waivers.

There is a significant and growing body of research that demonstrates the importance and success of family planning services under Medicaid. Policymakers at both the federal and the state levels are grappling with some of the issues critical to this success as they debate changes to the Medicaid program. As the future of the program is decided, it will be important to consider how these changes will affect access for the one in 10 women of reproductive age who rely on Medicaid for their health coverage and reproductive care each year.

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